When a review or appeal decision results in the revision of a rate, any additional operating cost included in the rate computation shall be offset by the amount allowed for trending and indexing in the following manner:

(a) If the cost increase was incurred prior to the rate year in question the additional operating cost shall be offset by the amount allowed for trending and indexing.

(b) If the cost increase was incurred during the rate year in question, the additional operating cost shall be offset by the amount allowed for indexing.

(NOTE: This does not represent a new policy, but enunciates the policy currently in effect.)

(j) Effective with the revised July 1, 1993 rates for acute care hospitals, the operating costs (trended and indexed) and the capital costs used for rate setting shall be limited to the pre-trending and index amounts from the prior year's rate setting trended and indexed (separately for operating and capital cost) at 150% of standard inflation factor. For purposes of the July 1, 1993 rate setting, rates shall be computed as if they were set on January 1, 1993 and for purposes of limiting cost increases to 150% of inflation, the cost data from the January 1, 1992 rate setting shall be used to compute the limitations on cost.

102. ESTABLISHMENT OF UPPER LIMIT:

An upper limit applicable to all inpatient costs except capital costs and professional component costs will be set at the weighted median cost for hospitals in each peer group, with the exception of hospitals serving a disproportionate number of poor patients (see Section 102A regarding hospitals determined to meet disproportionate share requirements). In addition, hospitals whose general characteristic is not that of an acute care hospital (i.e., because they are primarily rehabilitative in nature) will be exempted from operating upper limits.

General procedures for setting the upper limit are as follows. Utilizing cost reports (available as of December 1 of each year) for all hospitals, allowable Medicaid inpatient cost (excluding return on equity capital and those fixed costs associated with capital expenses) will be trended to the beginning of the prospective rate year. The trending factor will be established using the Data Resources, Inc., average rate of inflation applicable to the period being trended. The trending factor thus determined is utilized to establish the allowable Medicaid inpatient cost basis for indexing. Costs shall be limited to the cost report data used in the prior year's rate setting trended and indexed at 150% of the inflation factor.

The cost basis is then indexed for the prospective rate year to allow for projected inflation for the year. With the Medicaid return on equity capital then added, the result represents the

Medicaid inpatient allowable cost basis for rate setting, which is then converted to a per diem cost utilizing the latest available Medicaid inpatient bed day statistics for each hospital.

For purposes of applying an upper limit, hospitals are peer grouped according to bed size. Effective January 1, 1983 the peer groupings for this payment system will be: 0-50 beds, 51-100 beds, 101-200 beds, 201-400 beds, and 401 beds and up.

The hospital inpatient cost per diems are arrayed from lowest to highest by peer group. Hospitals exempted from operating upper limits are not included in the array(s). Newly constructed hospitals and newly participating hospitals will be excluded from the arrays until a cost report that contains twelve full months of data is available. The median cost per diem for each of the five (5) arrays will be based on the median number of patient days. The upper limit for each peer group containing facilities with more than 100 beds shall be computed at the median. The upper limit for each peer group of facilities with less than 101 beds shall be 110% of the median. In order to disassociate the designated teaching hospitals with their higher costs from other hospitals, these hospitals are removed from the array in order to set the upper limit for other hospitals in the class, except that pediatric teaching hospitals will remain in the array.

Department for Medicaid Services
General Policies and Guidelines
Hospitals

102A. DISPROPORTIONATE SHARE HOSPITALS

42 U.S.C. 1396r-4, as amended, imposed new requirements regarding payments to hospitals considered to be serving a disproportionate share of indigent individuals (i.e. the term "disproportionate share hospital"). This section of the manual specifies which hospitals shall be classified as disproportionate share, and the payment adjustment made with regard to them.

(a) Classification

(1) Disproportionate share hospitals are defined as those hospitals meeting the following criteria:

A. The hospital shall have at least two (2) obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to Medicaid eligible individuals. If the hospital is located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician' includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures.

B. Item A above shall not apply to a hospital if:

1. The inpatients are predominantly individuals under eighteen (18) years of age; or

2. The hospital did not offer nonemergency obstetric services as of December 21, 1987.

C. In addition to the criteria in (A) and (B). the hospital shall have a Medicaid inpatient utilization rate of not less than one (1) percent.

(b) The following upper limits and payment principles shall apply to disproportionate share hospitals.

(1) Acute care hospitals with Medicaid utilization of twenty (20) percent or higher, or having twenty-five (25) percent or more nursery days resulting from Medicaid covered deliveries as compared to the total number of allowable Medicaid days, shall have an upper limit set at 120 percent of the weighted median per diem cost for hospitals in the array. In addition to the per diem amount computed in this manner, the hospitals shall be paid (as appropriate) additional amounts for services to infants under age six (6) (as shown in Section 102B). The hospitals shall also be paid their disproportionate share hospital payments as appropriate.

(2) Designated state teaching hospitals and major affiliated pediatric teaching hospitals (i.e., those affiliated with or a part of the University of Kentucky and the University of Louisville) shall have an. upper limit set at 126 percent of the weighted median per diem cost for all other hospitals of comparable size (401 beds and up). The pediatric teaching hospitals shall also be paid, in addition to the facilities base rate, an amount which is equal to two (2) percent of the base for each one (1) percent of Medicaid occupancy but this amount shall not exceed the prospective reasonably determined uncompensated Medicaid cost to the facility. In addition to the per diem amount computed using the limits specified in this paragraph, the hospitals shall be paid (as appropriate) additional amounts for services to infants under age six (6) (as Shown in Section 102B). The hospitals shall also be paid disproportionate share hospital payments as appropriate.

(3) Mental hospitals with Medicaid utilization of thirty-five (35) percent or higher shall have an upper limit set at 115 percent of the weighted median per diem cost for hospitals in the array. The hospitals shall also be paid disproportionate share hospital payments as appropriate.

(4) All other disproportionate share acute care hospitals shall have their upper limit set at the weighted median per diem of the cost f or hospitals in the array. In addition to the per diem amount computed in this manner, the hospitals shall be paid (as appropriate) additional amounts for services to infants under age six (6) (as shown in Section 1023). The hospitals shall also be paid disproportionate share hospital payments as appropriate.

(c) Frequency of Review

Except as otherwise specified in this paragraph, determination of disproportionate share hospital status shall be made prior to the beginning of each universal rate year based upon prior year data. Once determined by the Department, disproportionate status shall not be revised for that rate year. For psychiatric hospitals, the Department shall accept annually a patient census as documentation of Medicaid occupancy.

(2) Designated state teaching hospitals and major affiliated pediatric teaching hospitals (i.e., those affiliated with or a part of the University of Kentucky and the University of Louisville) shall have an upper limit set at 126 percent of the weighted median per diem cost for all other hospitals of comparable size (401 beds and up). The pediatric teaching hospitals shall also be paid, in addition to the facilities' base rate, an amount which is equal to two (2) percent of the base for each one (1) percent of Medicaid occupancy but this amount shall not exceed the prospective reasonably determined uncompensated Medicaid cost to the facility. In addition to the per diem amount computed using the limits specified in this paragraph, the hospitals shall be paid (as appropriate) additional amounts for services to infants under age six (6) (as shown in section (c)(2)). The hospitals shall also be paid disproportionate share hospital payments as appropriate.

(3) Mental hospitals with Medicaid utilization of thirty-five (35) percent or higher shall have an upper limit set at 115 percent of the weighted median per diem cost for hospitals in the array. The hospitals shall also be paid disproportionate share hospital payments as appropriate.

(4) All other disproportionate share acute care hospitals shall have their upper limit set at the weighted median per diem of the cost for hospitals in the array. In addition to the per diem amount computed in this manner, the hospitals shall be paid (as appropriate) additional amounts for services to infants under age six (6) (as shown in section (c)(2)). The hospitals shall also be paid disproportionate share hospital payments as appropriate.

(c) Frequency of Review

Classification of disproportionate share hospitals shall be made prospectively prior to the beginning of each universal rate year. Classification, once determined by the Department, shall not be revised for that rate year.